Brendan V. Sullivan, Jr.
Steven M. Cady
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, D.C. 20005
Tel.: 202-434-5321
scady@wc.com

Maren R. Norton
STOEL RIVES LLP
600 University Street, Suite 3600
Seattle, WA 98101
Tel.: 206-624-0900
maren.norton@stoel.com

Attorneys for Defendants

Honorable Salvador Mendoza, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

CYNTHIA HARVEY, individually and on behalf of all others similarly situated,

Plaintiff,

v.

CENTENE MANAGEMENT COMPANY, LLC and COORDINATED CARE CORPORATION,

Defendants.

No. 2:18-CV-00012-SMJ

MOTION TO DISMISS SECOND AMENDED COMPLAINT

(Oral Argument Requested)

NOTE ON MOTION CALENDAR:
November 20, 2018 at 10:00 a.m. in Spokane

TABLE OF CONTENTS

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

TABLE OF AUTHORITIES

FEDERAL CASES

STATE CASES

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

STATUTES, RULES, AND REGULATIONS

OTHER AUTHORITIES

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

Defendants Coordinated Care Corporation (Coordinated Care) and Centene Management Company (CMC), by undersigned counsel, hereby move to dismiss the Second Amended Complaint in this action pursuant to Rules 8(a) and 12(b)(6) of the Federal Rules of Civil Procedure.

PRELIMINARY STATEMENT

In her third attempt to plead a valid claim, Plaintiff continues to assert that she paid too much for health insurance because she allegedly did not get all the benefits she was promised. As such, her Second Amended Complaint seeks to second-guess the work of the Washington State Office of the Insurance Commissioner (Insurance Commissioner), which reviewed the insurance policies and approved the insurance rates that Plaintiff paid. Plaintiff is asking this Court to step into the shoes of the Insurance Commissioner and pass on the adequacy of health-insurance provider networks and the propriety of approved health-insurance premiums. Those are matters that the Insurance Commissioner is specifically charged with overseeing—and is in fact overseeing. Under recent unanimous controlling authority from the Washington Supreme Court, Plaintiff's attempt at an end-run around the Insurance Commissioner's authority is barred by the filed-rate doctrine. While Plaintiff's latest complaint primarily aims to plead around that doctrine by reframing her damages claim, the revisions in fact only manage to

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

affirm the doctrine's applicability. This case should therefore be dismissed under Washington's filed-rate doctrine.

In addition, the Second Amended Complaint fails to plead a breach of contract. Despite multiple attempts to replead, the Complaint's factual allegations –focused on an alleged inadequate provider network and alleged failure to properly reimburse claims—are still too thin to state a valid claim.

Finally, even if the Second Amended Complaint survives (and it should not), the claims against Centene Management Company should be dismissed. Plaintiff does not allege that she had any contractual relationship with CMC. CMC merely provides management and administrative services to Coordinated Care and other Centene subsidiaries. Plaintiff pleads no facts suggesting that CMC is Coordinated Care's alter ego, and thus there is no basis for including CMC as a defendant.

Because Plaintiff has been given three chances to plead a valid claim and has failed to do so, dismissal should be with prejudice.

BACKGROUND

Plaintiff filed her initial complaint on January 11, 2018. After Defendants moved to dismiss and the motion was fully briefed, on the eve of oral argument, Plaintiff filed a First Amended Complaint, which was a whittled-down version of

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

her initial complaint. Plaintiff abandoned her Affordable Care Act and Texas state law claims, dropped some defendants, and abandoned her attempt to certify a "nationwide" class. Once the case was limited to Washington claims, Defendants again moved to dismiss, this time focusing on the Washington filed-rate doctrine. Once again, Plaintiff chose to amend rather than defend the pleading she had filed.

In her Second Amended Complaint, Plaintiff again asserts claims for breach of contract and unfair business practices under the Washington Consumer Protection Act against Coordinated Care and CMC. Plaintiff's claims still revolve around her alleged inability to access certain providers and the denial of certain claims. She now purports to bring the action on behalf of "[a]ll persons in the state of Washington who were insured by Defendants' Ambetter insurance product which was purchased through an ACA [Health Insurance Exchange] from January 11, 2012 to the present." SAC ¶ 59. But, as set forth in detail below, the claims remain deficient and should be dismissed.

ARGUMENT

Plaintiff asserts that, by maintaining an allegedly inadequate provider network and denying claims, Coordinated Care and CMC breached Plaintiff's contract with Coordinated Care and violated the Washington Consumer Protection Act. The filed-rate doctrine precludes both of Plaintiff's claims because the claims

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

challenge insurance rates that were filed with and approved by the Insurance Commissioner. Even if Plaintiff's claims were not precluded by the filed-rate doctrine, her breach-of-contract claim must be dismissed because it is inadequately pled. Finally, Plaintiff cannot maintain either claim against CMC on an alter-ego theory, and CMC should be dismissed from the case.

I. The Filed-Rate Doctrine Precludes Both of Plaintiff's Claims.

To adjudicate Plaintiff's claims would require this Court to second-guess Coordinated Care's insurance rates, which have been approved by the Insurance Commissioner. In *McCarthy Finance, Inc. v. Premera*, 347 P.3d 872, 875 (Wash. 2015), the Washington Supreme Court unanimously held that the filed-rate doctrine bars precisely this kind of judicial second-guessing of agency-regulated ratemaking. *Premera* is on all fours with this case, and mandates that Plaintiff's claims be dismissed.

As the *Premera* court explained, the Insurance Commissioner is charged with reviewing and approving health insurance premiums in Washington pursuant to a detailed framework of state laws and regulations. *Premera*, 347 P.3d at 875 (collecting relevant statutory and regulatory provisions). The Insurance Commissioner protects consumers from "benefits [that] . . . are 'unreasonable in relation to the amount charged for the contract.'" *Id*. (citations omitted). To that

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

end, the Insurance Commissioner is vested with the authority to approve or disapprove health insurance contracts and rates on a variety of grounds. Wash. Rev. Code § 48.44.020. One basis for disapproval is the failure to satisfy the minimum health insurance standards set forth in state regulations, *id*. § 48.44.020(2)(f), including the requirements for maintaining adequate provider networks. Wash. Admin. Code § 284-170-200. As part of the review process, the Insurance Commissioner requires insurers to submit detailed information concerning insurance rates and their ratemaking methodology. Wash. Rev. Code §§ 48.44.017(2) & 48.44.020(3). Rates and modifications of rates must go through the Insurance Commissioner's review and approval process before taking effect. *Id*. § 48.44.020(3).

The filed-rate doctrine is a doctrine of deference. It recognizes that courts should not intrude into ratemaking processes that are overseen and carefully regulated by agencies. The doctrine is a "court-created rule to bar suits against regulated utilities involving allegations concerning the reasonableness of the filed rates. This doctrine provides, in essence, that any 'filed rate'—a rate filed with and approved by the governing regulatory agency—is per se reasonable." *Premera*, 347 P.3d at 875 (citation omitted). Courts fashioned this limitation on their own power with two purposes in mind: "(1) to preserve the agency's primary

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

jurisdiction to determine the reasonableness of rates, and (2) to insure that regulated entities charge only those rates approved by the agency." *Id*. (citation omitted). To achieve those goals, courts will not reevaluate any filed and approved rates "because doing so would inappropriately usurp the agency's role." *Id*. at 873.

In *Premera*, the Washington Supreme Court unanimously applied the filed-rate doctrine to health insurance rates in a case analogous to this one. *See* 347 P.3d 872; *see also Heaphy v. State Farm Mut. Auto. Ins. Co*., No. C05 5404RBL, 2006 WL 278556, at *2 (W.D. Wash. Feb. 2, 2006) (affirming that filed-rate doctrine applies to claims related to insurance premiums). In that case, plaintiffs alleged that a group of insurers colluded and induced plaintiffs to purchase policies under false pretenses and then charged them excessive and deceptive rates. *Premera*, 347 P.3d at 873–74. They sought compensation for the excessive premium payments under the CPA. *Id*. at 874. The Washington Supreme Court affirmed dismissal of the plaintiffs' claims based on the filed-rate doctrine. The key question was "whether the claims and damages related to agency-approved rates . . . would necessarily require courts to reevaluate agency-approved rates." *Id*. at 875. The court concluded that, to evaluate whether the premiums charged were excessive, it would need to "determine what health insurance premiums would have been reasonable for the Policyholders to pay as a baseline." *Id*. at 876. Thus,

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

the "requested damages cause[d] [plaintiffs'] CPA claims to run squarely against the filed rate doctrine." *Id*.

That reasoning controls the outcome here: Plaintiff's Consumer Protection Act and breach-of-contract claims run squarely into the filed-rate doctrine. Plaintiff tries to avoid that problem by dividing her damages claims into three alternative theories: (1) a full refund of premiums paid; (2) a "Partial Refund" or the "difference in value" between the policy as represented and the policy as delivered; and/or (3) "Out-of-Pocket Expenses" that Plaintiff allegedly paid for covered services. SAC ¶ 76 & ¶ 85. With the first two damages theories, Plaintiff is asserting that the policy she purchased was worth nothing or worth less than the premiums paid, or in other words, that the premiums were excessive in relation to the benefits received—and thus she is owed a "refund."[1]

[1] Plaintiff tacks on out-of-pocket expenses as an alternative to a full or partial refund of premium payments without explaining what those expenses are or how she incurred them. It is not clear how the three forms of damages relate to each other. The additional claim for out-of-pocket expenses certainly does not change the fact that Plaintiff's damages claim seeks to challenge rates filed with and approved by the Insurance Commissioner.

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

To assess the refund that Plaintiff requests, this Court would have to set a "reasonable . . . baseline" for what Plaintiff should have paid for the policy and then subtract that amount from the premiums charged by Coordinated Care. *Premera*, 347 P.3d at 876. Clearly, calculating a refund would force the Court to reevaluate the insurance rates that the Insurance Commissioner has already reviewed and approved. *Premera* unanimously rejected a request for a refund of excessive premium payments, and this Court should too. *Premera*, 347 P.3d at 876; *see also Alpert v. Nationstar Mortgage LLC*, 243 F.Supp.3d 1176, 1183 (W.D. Wash. 2017) (applying the filed-rate doctrine to dismiss CPA and breach-of-contract claims where plaintiff sought "difference between what he was charged and the reasonable cost of insurance"); *Hardy v. Claircom Comm'cns Grp. Inc.*, 937 P.2d 1128, 495–96 (Wash. App. 1997) (dismissing CPA and breach-of-contract claims because "court would necessarily have to consider the reasonableness of the rates charged").

Plaintiff tries to address her clear filed-rate doctrine problem with a disclaimer that she is "not challenging the reasonableness of the rates filed with the Office of the Insurance Commissioner." SAC ¶ 14. According to Plaintiff, instead of challenging rates, her complaint is that Defendants failed to "actually deliver[] the insurance services for which its filed rates were approved by the [Insurance

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

Commissioner]," and that Defendants "misrepresented and made material omissions regarding the coverage actually provided." *Id.* This attempt to dodge the filed-rate doctrine only serves to reinforce its applicability. Excessive insurance rates and inadequate services are simply two sides of the same coin. As the U.S. Supreme Court explained 20 years ago: "Rates . . . do not exist in isolation. They have meaning only when one knows the services to which they are attached. Any claim for excessive rates can be couched as a claim for inadequate services and vice versa." *AT&T v. Cent. Office Tel., Inc.*, 524 U.S. 214, 223 (1998). Accordingly, "the filed-rate doctrine . . . bars suits challenging services, billing, or other practices when such challenges, if successful, would have the effect of changing the filed tariff." *Brown v. MCI, WorldCom Network Servs., Inc.*, 277 F.3d 1166, 1170 (9th Cir. 2002) (citing *AT&T*).

Those principles apply here: despite characterizing her claims as focused on the insurance benefits at issue, Plaintiff is still in effect alleging that the premiums she paid were too high in light of the benefits provided. By the same token, it does not matter that Plaintiff cloaks her claims in the language of misrepresentation, because the relief she seeks still requires the Court to reevaluate the reasonableness of filed rates. *See Hardy*, 937 P.2d at 1132 (applying filed-rate doctrine despite

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

plaintiffs' argument that they are "specifically challenging the allegedly deceptive advertising practices of [defendants], not the underlying rate").

Not only is the filed-rate doctrine an exact fit with Plaintiff's claims, but the policy rationale behind the doctrine—judicial deference to the regulatory agency in overseeing insurance rates—also applies with particular force here. *See Premera*, 347 P.3d at 875. As the Complaint describes, the Insurance Commissioner currently is reviewing Coordinated Care's provider networks and related issues. SAC ¶¶ 15–20. It does not make sense to allow a private litigant to police network adequacy when the Insurance Commissioner already is working with Coordinated Care on that very issue. The Insurance Commissioner is doing his job—ensuring that the benefits provided under the policies correspond to the rates charged. Dismissing Plaintiff's claims under the filed-rate doctrine would not leave her without recourse—she can bring complaints directly to Coordinated Care or the Insurance Commissioner and receive appropriate remedies. Indeed, Ms. Harvey admits that she has successfully availed herself of remedies available under her insurance contract, including making complaints to Coordinated Care and the Insurance Commissioner. SAC ¶ 56. This Court need not step into this ongoing administrative process. Instead, it should reject Plaintiff's challenge to rates

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

approved by the Insurance Commissioner and dismiss Plaintiff's Second Amended Complaint as barred by the filed-rate doctrine.

II. The Second Amended Complaint Fails To Adequately Plead Breach of Contract.

Even if Plaintiff's breach-of-contract claim were to survive the filed-rate doctrine, it still would fail on its own terms. Despite filing two amended complaints, Plaintiff has made next to no attempt to improve her deficient breach-of-contract claim. To survive a motion to dismiss, Plaintiff's claims "must contain sufficient allegations of underlying facts to give fair notice and to enable the opposing party to defend itself effectively." *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011). Put slightly differently, the complaint's allegations must "give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests." *Pickern v. Pier 1 Imps. (U.S.), Inc.*, 457 F.3d 963, 968 (9th Cir. 2006) (internal quotation marks omitted). Here, the allegations fail under these standards.

The Second Amended Complaint plucks from the insurance contract some broad language delineating members' rights, SAC ¶¶ 69–70, and makes a series of "mere conclusory statements" that Coordinated Care failed to meet those obligations. *Villegas v. United States*, 926 F. Supp. 2d 1185, 1195 (E.D. Wash.

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

2013) (citation and internal quotation marks omitted). The only specific allegations concern one instance in which Ms. Harvey allegedly could not access an in-network emergency room physician and one other instance in which part of her claim for a covered procedure was denied. SAC ¶¶ 54–55. Plaintiff neglects to articulate how these two examples, even if true, show that Coordinated Care's provider network as a whole was inadequate. Taking Plaintiff's tack, any policyholder could transform small-scale grievances into a federal case of breach of contract. That approach gives Coordinated Care no notice of *how* the alleged conduct breached the cited contractual provisions or *how* Coordinated Care fell short of any obligations.

In fact, the health insurance contract itself shows that individual grievances like Ms. Harvey's do not rise to the level of a breach of contract. Coordinated Care anticipated that insureds may experience issues with accessing providers and built into the contract a grievance and appeal process to address those issues. Second Decl. of Tricia Dinkelman ("Reply Decl.") Ex. 1, ECF No. 33-2 at 74–78 (excerpts from contract between Coordinated Care Corp. and Plaintiff Harvey). That process provides for an internal appeal of denied claims and, if a policyholder is not satisfied with the outcome, further external review by an independent claims review organization. *Id*. The inclusion of this detailed procedure shows that the

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

parties to the contract did not intend for issues that could be handled through the grievance process to turn into lawsuits in federal court. As noted above, Ms. Harvey admits that she successfully availed herself of the appeal process on multiple occasions. SAC ¶ 56. Where the contract expressly provides for appeals to resolve disputes over benefit determinations, it cannot be a breach that Plaintiff was "forced to complete the process of appeal." *Id*. Accordingly, Plaintiff should not be allowed to bring a separate contract claim based on issues she already addressed through that process.

Moreover, as to Ms. Harvey's allegation that she was billed for out-of-network emergency room services, her contract with Coordinated Care expressly put her on notice of this possibility: "When receiving care at an in-network Ambetter Hospital, *some Hospital-Based Providers may not be in-network. . . . While an in-network Hospital's emergency department is contracted with Ambetter, the Providers within the department may not be*. As a result, these out-of-network Hospital-Based Providers *may bill you for the difference* between what Ambetter pays them and their total bill – this is known as Balance Billing." Reply Decl. Ex. 2 at 32 (emphasis added). In light of this language in Plaintiff's contract, the fact that Plaintiff's emergency room provider billed Ms. Harvey cannot be a breach of her contract with Coordinated Care.

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

Plaintiff's allegation of damages is likewise deficient. By requesting three forms of compensatory damages, Plaintiff is demanding a full or partial refund of her premium payments and/or reimbursement for out-of-pocket expenses she allegedly incurred for care that her plan should have covered. None of those is a valid theory of damages. First, Plaintiff is not eligible for a full refund or the "Benefit of the Bargain." SAC ¶ 76. That would only be appropriate if Plaintiff had obtained no benefits at all under her policy, which is not the case here. The Complaint in fact describes services that Plaintiff received under her plan and payments she received after appealing denied claims. *Id*. ¶¶ 54–56.

Second, Plaintiff's damages theories are impermissibly vague. Her claim amounts to saying that some undefined portion of what Plaintiff paid Coordinated Care and/or some undefined out-of-pocket expenses represents Plaintiff's damages. In other words, Defendants allegedly owe Plaintiff some or all of whatever cost she incurred for covered care. This claim provides no notice of what compensation Plaintiff is seeking or how that compensation is tied to the alleged contractual breach, making it too vague to support a claim for relief. *See Adolf Jewelers, Inc. v. Jewelers Mut. Ins. Co.*, No. 3:08-CV-233, 2008 WL 2857191, at *4 (E.D. Va. July 21, 2008) ("[A]llegations that [plaintiff] (1) incurred unnecessary and considerable costs and other damages, (2) was inconvenienced, and (3) lost time do

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

not give [defendant insurance company] fair notice of the grounds for [plaintiff's] claim." (internal quotation marks omitted)). Plaintiff's breach-of-contract claim—despite being presented a third time—remains facially inadequate and should be dismissed.

III. Plaintiff Fails To State a Claim Against CMC Under an Alter Ego Theory.

As an apparent admission that her alter ego theory against Centene Corporation in the original complaint was unworkable, Plaintiff dropped that entity as a defendant. But Plaintiff has added Centene Management Company as a defendant and now advances an even more tenuous alter ego theory—that this Court should pierce the veils of both Coordinated Care *and* CMC through their connection with Centene Corporation, and hold CMC liable for Coordinated Care's alleged wrongdoing.

This new alter ego theory fails like the first one. Plaintiff again ignores a foundational requirement of the alter ego doctrine—that the corporate form must be respected unless it has been misused to commit a fraud or injustice. Plaintiff makes no allegations at all explaining how the relationship between Coordinated Care and CMC effects any fraud or injustice on Plaintiff. But even as to the other

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

main requirement of the alter ego doctrine—the total domination and control of one corporation by another—Plaintiff's allegations fall short.

A. Plaintiff Fails To Allege Fraud or Injustice.

Whatever the relationship between two related corporate entities, veil-piercing is not appropriate unless it is required to avoid a fraud or injustice on the plaintiff. *See, e.g., Meisel v. M & N Modern Hydraulic Press Co.*, 645 P.2d 689, 692 (Wash. 1982) (en banc) (recognizing that veil-piercing is appropriate only where it is "necessary and required to prevent unjustified loss to the injured party" (internal quotation marks and citation omitted)); *Massey v. Conseco Servs., L.L.C.*, 879 N.E.2d 605, 609 (Ind. App. 2008) (requiring that plaintiff show that "the misuse of the corporate form would constitute a fraud or promote injustice" (internal quotation marks and citation omitted)); *Consumer's Co-op v. Olsen*, 419 N.W.2d 211, 214 (Wis. 1988) (requiring plaintiff to show that "applying the corporate fiction would accomplish some fraudulent purpose, operate as a constructive fraud, or defeat some strong equitable claim" (internal quotation marks and citation omitted)).[2]

[2] Because Plaintiff seeks to disregard the corporate separateness of both Coordinated Care (an Indiana corporation) and CMC (a Wisconsin corporation), Indiana and Wisconsin law likely apply. *See* Restatement (Second) of Conflict of

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

The Second Amended Complaint lacks any allegations that suggest this prong of the alter ego inquiry is met. The sole factual basis of Plaintiff's alter ego case is a one-paragraph cut-and-paste from a financial statement, which says that Coordinated Care contracts with CMC for the provision of various "management services." SAC ¶ 2. From that point forward, Plaintiff proceeds to ignore any distinction between Coordinated Care and CMC. *See id.* (stating that the term "Centene" is used to "refer to the joint activities of Centene Management Company, LLC and Coordinated Care").

Even if such a management services agreement were improper (as is shown below, *see infra* p. 19, it is not), Plaintiff fails to suggest any reason why that arrangement is fraudulent or unjust as to her. Notably absent from the Second Amended Complaint is any allegation that Coordinated Care is undercapitalized or unable financially to provide Plaintiff appropriate relief. In fact, Plaintiff's allegations suggest the opposite; she states that she has successfully used the appeal process provided for in her insurance contract to secure reimbursement from Coordinated Care. SAC ¶ 56. This is reason enough to dismiss Plaintiff's

---

Laws § 307 (law of "state of incorporation" applies to questions of shareholder liability). The alter ego tests of Indiana, Wisconsin, and Washington are broadly similar, and Plaintiff's alter ego allegations would fail under each one.

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

alter ego claim. If Coordinated Care can provide Plaintiff sufficient relief, then veil-piercing clearly is not necessary. *See, e.g.*, *Poulos v. Naas Foods, Inc.*, 959 F.2d 69, 74 (7th Cir. 1992) (Wisconsin law) (recognizing that veil-piercing was not "required to avoid . . . possible fraud" because plaintiff could not allege "that the assets of [the subsidiary] would be insufficient to satisfy a judgment"); *Phillips v. USAA Cas. Ins. Co.*, No. 2:16-CV-0381-TOR, 2017 WL 26907, at *3 (E.D. Wash. Jan. 3, 2017) (Washington law) (declining to add parent entity under veil-piercing theory because piercing was not "necessary to prevent an unjustified loss," as its subsidiary "is willing to pay the amount . . . owed").

Moreover, Plaintiff has not pled any causal connection between Defendants' corporate form and Plaintiff's alleged injury, nor has Plaintiff pled any misuse of the corporate form. *See, e.g.*, *Meisel*, 645 P.2d at 693 ("Intentional misconduct must be the cause of the harm that is avoided by disregard."); *CBR Event Decorators, Inc. v. Gates*, 962 N.E.2d 1276, 1282–83 (Ind. App. 2012) ("[T]he fraud or injustice alleged by a party seeking to pierce the corporate veil must be caused by, or result from, misuse of the corporate form."); *Consumer's Co-op*, 419 N.W.2d at 218 (misuse of corporate form "must proximately cause the injury or unjust loss complained of"). Plaintiff alleges that she was harmed because Coordinated Care did not appropriately reimburse her for various treatments. SAC

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

¶¶ 54–55. These allegations have nothing at all to do with the relationship between Coordinated Care and CMC.

B. Plaintiff Fails To Allege Complete Domination.

Plaintiff does no better on the other prong of the alter ego test, which requires a showing that one company "complete[ly] dominat[ed]" the other. *Consumer's Co-op*, 419 N.W.2d at 217–18. The only basis for Plaintiff's suggestion that CMC dominates Coordinated Care is that, under a "management services agreement," CMC provides Coordinated Care a number of management and administrative services. SAC ¶ 2. These arrangements are common and not indicative of a failure to respect corporate separateness. *See In re Western States Wholesale Natural Gas Antitrust Litig.*, No. 03-cv-1431 *et al.*, 2009 WL 455658, at *11–*12 (D. Nev. Feb. 23, 2009); *Everitt v. Dover Downs Ent'mt Inc.*, No. 98-cv-6116, 1999 WL 374163, at *6 (E.D. Pa. June 9, 1999). As the Court in *Everitt* noted, in a traditional holding company structure (like Centene's), it "makes economic sense" for "[c]ertain activities [to be] centralized." *Everitt*, 1999 WL 374163, at *6. That is all that Plaintiff has alleged that Defendants have done. Accordingly, her control allegations fall far short, and CMC should be dismissed.

STOEL RIVES LLP
ATTORNEYS
600 University Street, Suite 3600, Seattle, WA 98101
Telephone 206.624.0900

CONCLUSION

For the foregoing reasons, the Court should dismiss the Second Amended Complaint as to all Defendants with prejudice.

Dated: September 12, 2018

Respectfully submitted,

STOEL RIVES LLP

By: */s/ Maren R. Norton*
Maren R. Norton
600 University Street, Suite 3600
Seattle, WA 98101
Tel.: 206-624-0900
maren.norton@stoel.com

Brendan V. Sullivan, Jr. (admitted *Pro Hac Vice*)
Steven M. Cady (admitted *Pro Hac Vice*)
WILLIAMS & CONNOLLY LLP
725 Twelfth Street, N.W.
Washington, D.C. 20005
Tel.: 202-434-5321
Fax: 202-434-5029
scady@wc.com

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on September 12, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System, which in turn automatically sent a Notice of Electronic Filing to all parties in the case who are registered users of the CM/ECF system. The Notice of Electronic Filing for the foregoing specifically identifies recipients of electronic notice.

/s/ Maren R. Norton

Maren R. Norton
600 University Street, Suite 3600
Seattle, WA 98101
Tel.: 206-624-0900
maren.norton@stoel.com